of safety and first aid to the people of Delaware. As a former Governor, I know first hand the important role that these dedicated and vital organizations play in recruiting and retaining young men and women in the public service arena. Mr. Speaker, I am proud to have this privilege to extend my warmest wishes for a successful conference. I salute and thank them for their unwavering commitment to excellence and the example they set for all of us. Their efforts are deeply appreciated.

A TRIBUTE TO REVEREND VERTANES KALAYJIAN

HON. FRANK PALLONE, JR.

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 28, 2000

Mr. PALLONE. Mr. Speaker, I am honored today to recognize the achievements and spiritual leadership of the Rev. Fr. Archpriest Vertanes Kalayjian, pastor of St. Mary's Armenian Church in Washington, DC. On October 1, the Washington-Baltimore Armenian community will be honoring this most outstanding religious and community leader among Armenian-Americans in the United States. On this date, parishioners and many others will recognize the 40th anniversary of Rev. Kalayjian's ordination into the priesthood.

Those who gather from across the country and the world on October 1 will also recognize the 25th anniversary of the service to St. Mary's of Rev. Kalayjian and Yeretzgin Anahid Kalayjian, his wife of 31 years.

Mr. Speaker, as the cochairman of the Congressional Caucus on Armenian Issues, I am acutely aware of the many extraordinary contributions Father Kalayjian and Mrs. Kalayjian have made to the Armenian community in the United States. Over the years, his outstanding missionary and humanitarian efforts have also been of immeasurable help to the struggling families and youth of Armenia, as well as Armenian families spread throughout Eastern Europe and the world.

In his important assignment as the head of the pastorate in Washington, DC, he has played a crucial role representing the diocese in the Congress, the State and Justice Departments and the Brookings Institute. Every year, Father Kalayjian briefs the Appeal of Conscience Conferences, the State Department's Foreign Service Institute, on the status of the Armenian communities in Eastern Europe and in the former Soviet Union republics.

Father Kalayjian was born in Aleppo, Syria, and was ordained on February 7, 1960, at the St. James Seminary of Jerusalem Armenian Patriarchate. He came to the United States in December 1964 and was assigned to the St. George Parish in Waukegan, IL. In addition to his pastoral work, he did Christian Education; Biblical Studies and Public Administration at Lake Forest, Carthage College and Southeastern University.

In subsequent years, he served the parishes of Holy Cross, Union City, NJ; and St. Mary's Church in Elberon, NJ (now St. Stephanos and in my congressional district.)

In 1976, he assumed the pastorate here in Washington, where he serves the St. Mary's community, including nearby Baltimore city and the neighboring towns.

During most of this career as a servant of God, Mrs. Kalayjian has been a partner, colleague and spiritual supporter to her husband's ministry. She has contributed invaluably to the growth and spiritual well-being of St. Mary's Parish. She has been surrogate mother, nurse, chaplain, Armenian Cultural Program director and advisor to successive camp directors and committees at the Armenian General Benevolent Union's Camp Nubar in the Catskills in New York. The AGBU promotes philanthropy, human rights land education throughout the world.

Her services to the Armenian people have included numerous other missionary and humanitarian initiatives in Armenia, including missionary outreach in the aftermath of the earthquake. Her early training and work as a pediatric nurse and nursing supervisor only added to the invaluable contributions she has made to families in need here and in Armenia.

Mr. Speaker, I am proud to call these tireless and devoted humanitarians my friends. I wish them both a most deserved and joyous celebration on October 1.

DRUG PROFITS DISTORTING HOW DOCTORS PRESCRIBE?

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 28, 2000

Mr. STARK. Mr. Speaker, in the September 19th CONGRESSIONAL RECORD, I provided some documentation of how profits from prescribing drugs may be causing some doctors to over-prescribe or change their prescribing patters, not on the basis of medical need, but simply for the sake of money.

The enormous profits available to many doctors on the ''spread'' between what Medicare and other payers reimburse for a drug (the average wholesale price), and what that drug is really available for 'on the street' may be one of the most serious ethical issues in American medicine today.

I submit into the CONGRESSIONAL RECORD a letter I've sent to the Agency for Healthcare Research and Quality on why this is a problem which must be investigated as soon as possible and a memo in reference to physician prescribing practices in Japan.

The Justice Department and the HHS Inspector General have, I believe, documents which show how drug companies have manipulated the AWP to move doctors to prescribe various drugs. These documents raise the most serious questions about the integrity of health care delivery.

The letters follow:

COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC, August 18, 2000.

Dr. JOHN EISENBERG,
Administrator, Agency for Healthcare Research and Quality, Washington, DC.

DEAR JOHN: Nice Norman Rockwell exhibit at the National Gallery—and nice paintings of doctors the way we want them to be: grandfatherly figures we can totally trust our lives with.

But the data in various areas of health care show that physicians are just like the rest of us mortals: they are economic animals; they respond to financial incentives. We see this economic influence in the fact that for-profit hospitals do more Caesarian sections than not-for-profit hospitals, because the fees and profits are higher for a C-section. We see this in the extensive literature that physicians who own or invest in a downstream service (such as a lab or MRI) tend to order many more tests (and more expensive tests) than doctors who do not invest in such facilities. We see this in foreign countries where physician income is much lower than it is in the United States on average, but physicians are allowed to make money on each prescription that they write. As a result in Japan (and in the past Italy) the patients get many more pills than Americans do. Doctors in those countries make money by pushing medicines on their unsuspecting patients.

I fear the same thing may be happening here in the United States on certain drugs, and I would like to request AHRQ's help in determining whether Medicare's Average Wholesale Price system of paying doctors for certain medicines may have caused some distortions in prescribing practice.

As you know, after years of work, the Justice Department and the HHS OIG have finally persuaded Medicare and Medicaid to use a more realistic set of data for purposes of paying doctors 95% of the AWP. The use of the more accurate AWP data will save taxpayers and patients hundreds of millions of dollars a year. Of course, the physicians the savings are coming from are lobbying furiously to block the cuts, saying that they have used the profits from the difference between 95% of the AWP and the real purchase price to run their offices. HCFA is investigating whether the practice expense (PE) payment to doctors needs to be adjusted to pay more accurately for the cost of administering the drugs. If the PE payment is inadequate, we certainly should adjust it.

But we should not, I believe, pay more for the drug than the cost to the doctor of purchasing the drug. Otherwise, if these other domestic and foreign examples apply, we will see a misuse of the drug.

To determine whether there has been misuse, would it be possible for AHRQ to examine the use of chemotherapy drugs in settings where there is no financial incentive to either over use or not use (e.g., Kaiser, VA, DoD, etc.) versus chemotherapy drug use in private, for profit, physician-run oncology practices? Adjusting for severity of illness, are the outcomes (remission, deaths, etc.) similar in these settings? Is more or less chemotherapy medicine used? for patients who die, is chemotherapy administered longer in one setting versus another? is chemotherapy administered beyond a point where the patient might be considered terminal?

Thank you for your help in understanding whether there are different patterns of chemotherapy drug use, depending on whether one profits from the drugs' use, and if so, whether there is any better outcome and quality as a result of additional chemotherapy usage.

Sincerely,

PETE STARK,
Ranking Member.

In Japan, where physicians and hospitals are allowed to make money on each prescription they write, there are high levels of drug utilization and incentives for drug overperscribing. For example—